

(b) *Standard: Delivery of services.* Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital's medical staff to order the services in accordance with hospital policies and procedures and State laws.

(1) All rehabilitation services orders must be documented in the patient's medical record in accordance with the requirements at § 482.24.

(2) The provision of care and the personnel qualifications must be in accordance with national acceptable standards of practice and must also meet the requirements of § 409.17 of this chapter.

[51 FR 22042, June 17, 1986, as amended at 72 FR 66406, Nov. 27, 2007; 75 FR 50418, Aug. 16, 2010]

§ 482.57 Condition of participation: Respiratory care services.

The hospital must meet the needs of the patients in accordance with acceptable standards of practice. The following requirements apply if the hospital provides respiratory care service.

(a) *Standard: Organization and Staffing.* The organization of the respiratory care services must be appropriate to the scope and complexity of the services offered.

(1) There must be a director of respiratory care services who is a doctor of medicine or osteopathy with the knowledge, experience, and capabilities to supervise and administer the service properly. The director may serve on either a full-time or part-time basis.

(2) There must be adequate numbers of respiratory therapists, respiratory therapy technicians, and other personnel who meet the qualifications specified by the medical staff, consistent with State law.

(b) *Standard: Delivery of Services.* Services must be delivered in accordance with medical staff directives.

(1) Personnel qualified to perform specific procedures and the amount of supervision required for personnel to carry out specific procedures must be designated in writing.

(2) If blood gases or other laboratory tests are performed in the respiratory

care unit, the unit must meet the applicable requirements for laboratory services specified in § 482.27.

(3) Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital's medical staff to order the services in accordance with hospital policies and procedures and State laws.

(4) All respiratory care services orders must be documented in the patient's medical record in accordance with the requirements at § 482.24.

[51 FR 22042, June 17, 1986; 51 FR 27848, Aug. 4, 1986, as amended at 57 FR 7136, Feb. 28, 1992; 75 FR 50418, Aug. 16, 2010]

§ 482.58 Special requirements for hospital providers of long-term care services ("swing-beds").

A hospital that has a Medicare provider agreement must meet the following requirements in order to be granted an approval from CMS to provide post-hospital extended care services, as specified in § 409.30 of this chapter, and be reimbursed as a swing-bed hospital, as specified in § 413.114 of this chapter:

(a) *Eligibility.* A hospital must meet the following eligibility requirements:

(1) The facility has fewer than 100 hospital beds, excluding beds for newborns and beds in intensive care type inpatient units (for eligibility of hospitals with distinct parts electing the optional reimbursement method, see § 413.24(d)(5) of this chapter).

(2) The hospital is located in a rural area. This includes all areas not delineated as "urbanized" areas by the Census Bureau, based on the most recent census.

(3) The hospital does not have in effect a 24-hour nursing waiver granted under § 488.54(c) of this chapter.

(4) The hospital has not had a swing-bed approval terminated within the two years previous to application.

(b) *Skilled nursing facility services.* The facility is substantially in compliance with the following skilled nursing facility requirements contained in subpart B of part 483 of this chapter.

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(1) Resident rights (§ 483.10 (b)(3), (b)(4), (b)(5), (b)(6), (d), (e), (h), (i), (j)(1)(vii), (j)(1)(viii), (l), and (m)).

(2) Admission, transfer, and discharge rights (§ 483.12 (a)(1), (a)(2), (a)(3), (a)(4), (a)(5), (a)(6), and (a)(7)).

(3) Resident behavior and facility practices (§ 483.13).

(4) Patient activities (§ 483.15(f)).

(5) Social services (§ 483.15(g)).

(6) Discharge planning (§ 483.20(e)).

(7) Specialized rehabilitative services (§ 483.45).

(8) Dental services (§ 483.55).

[72 FR 60788, Oct. 26, 2007. Redesignated at 79 FR 27155, May 12, 2014]

Subpart E—Requirements for Specialty Hospitals

SOURCE: 72 FR 15273, Mar. 30, 2007, unless otherwise noted.

§ 482.60 Special provisions applying to psychiatric hospitals.

Psychiatric hospital must—

(a) Be primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons;

(b) Meet the conditions of participation specified in §§ 482.1 through 482.23 and §§ 482.25 through 482.57;

(c) Maintain clinical records on all patients, including records sufficient to permit CMS to determine the degree and intensity of treatment furnished to Medicare beneficiaries, as specified in § 482.61; and

(d) Meet the staffing requirements specified in § 482.62.

[72 FR 60788, Oct. 26, 2007]

§ 482.61 Condition of participation: Special medical record requirements for psychiatric hospitals.

The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.

(a) *Standard: Development of assessment/diagnostic data.* Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for

the psychiatric condition for which the patient is hospitalized.

(1) The identification data must include the patient's legal status.

(2) A provisional or admitting diagnosis must be made on every patient at the time of admission, and must include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

(3) The reasons for admission must be clearly documented as stated by the patient and/or others significantly involved.

(4) The social service records, including reports of interviews with patients, family members, and others, must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.

(5) When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.

(b) *Standard: Psychiatric evaluation.* Each patient must receive a psychiatric evaluation that must—

(1) Be completed within 60 hours of admission;

(2) Include a medical history;

(3) Contain a record of mental status;

(4) Note the onset of illness and the circumstances leading to admission;

(5) Describe attitudes and behavior;

(6) Estimate intellectual functioning, memory functioning, and orientation; and

(7) Include an inventory of the patient's assets in descriptive, not interpretative, fashion.

(c) *Standard: Treatment plan.* (1) Each patient must have an individual comprehensive treatment plan that must be based on an inventory of the patient's strengths and disabilities. The written plan must include—

(i) A substantiated diagnosis;

(ii) Short-term and long-range goals;

(iii) The specific treatment modalities utilized;

(iv) The responsibilities of each member of the treatment team; and

(v) Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

(2) The treatment received by the patient must be documented in such a